



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE FORTH WORTH
PO BOX 1353
FRISCO TEXAS 75034

Respondent Name

CITY OF FORT WORTH

Carrier's Austin Representative

Box Number 04

MFDR Tracking Number

M4-13-2615-01

MFDR Date Received

June 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration letter: "Received denials stating 'medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. Name on notes SL Silvey, PT'. I would like to point out that the first PT evaluation that SL Silvey completed on 10.23.2012 was paid in full. These claims are follow-up PT evaluations. SL Silvey is our office licensed Physical Therapist. Dr. Lopez is the treating provider for this patient. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR."

Amount in Dispute: \$132.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the documentation provided these daily services were performed by SL Silvey, PT however the bills were submitted with Michael D Lopez, DC listed in Box 31. As required by the Texas Administrative Code the charges in question should have been submitted for review' in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care' [Texas Administrative Code Rule 133.20(e)(2)]."

Response Submitted by: Ricky D. Green, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2012 and January 22, 2013	97002	\$132.12	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedure for medical bill submission by health care

provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- Note – Per Rule 133.20 (e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. NAME ON NOTES SL SILVEY, PT
- 193 – Original payment decision maintained
- B20 – Srv partially/fully furnished by another provider
- GP – Service delivered under OP PT care plan

Issues

1. Did the requestor submit the bill in accordance with the provisions of Texas Labor Code §401.011?
2. Did the requestor submit the bill in accordance with the provisions of 28 Texas Administrative Code §133.20?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §401.011, titled, General Definitions, states in pertinent part. "In this subtitle... (21) "Health care practitioner" means: (A) an individual who is licensed to provide or render and provides or renders health care; or (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.
2. 28 Texas Administrative Code §133.20, titled, Medical Bill Submission by Healthcare Provider, states in pertinent part, (e)(2) states in pertinent part "(e) A medical bill must be submitted: 2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care..."
 - Review of the CMS-1500's for dates of service, November 20, 2012 and January 22, 2013 document in box 31 the signature of physician or supplier as Michael Lopez, D.C.
 - Review of the "Physical Therapy Evaluation" note documents that for dates November 20, 2012 and January 22, 2013, SL Silvey, PT rendered the physical therapy services.
 - The requestor also indicates in the request for reconsideration letter the following "SL Silvey is our office licensed Physical Therapist. Dr. Lopez is the treating provider for this patient."
 - The requestor did not meet the billing requirements of 28 Texas Administrative Code §133.20. As a result reimbursement cannot be recommended
3. For the reason stated above, the requestor is not entitled to reimbursement of the disputed charges rendered on November 20, 2012 and January 22, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September 13, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.